Hearing Consultants of Georgia

Lawrenceville
771 Old Norcross Road
Suite 135
Lawrenceville, GA 30046
(678) 710-3004
Tues & Thurs 9am - 5pm

Athens
1000 Hawthorne Avenue
Suite O
Athens, GA 30606
(678) 710-3004
Mon, Wed, & Fri 9am - 5pm

Patient Information

Patient _____ Age____ Date of Birth_____
Marital Status (S M W D) Occupation (current or previous) _____
Spouse_____
Address _____
Phone_____
City _____ State_____ Zip _____
Physician _____ Phone _____
Address _____
City _____ State_____ Zip _____
Email Address _____
Referral Reason _____

Confidential Patient Case History

Have you seen a Doctor in the last six months? ❑ Yes ❑ No
When was your last hearing test? _____
Have you had any surgery on your ears? ❑ Yes ❑ No
Do you have pain in the ear? ❑ Yes ❑ No
Do you have ringing in the ears? ❑ Yes ❑ No
Do you have drainage in the ears? ❑ Yes ❑ No
Have you experienced sudden or rapid hearing loss? ❑ Yes ❑ No
Do you have problems with dizziness or imbalance? ❑ Yes ❑ No
Which ear is worse? ❑R ❑L ❑ Same
Have you ever taken medication that is known to be harmful to your hearing? ❑ Yes ❑ No
Are you currently taking blood thinners? ❑ Yes ❑ No

Hearing History

Do you feel like people are mumbling as they speak? ❑ Yes ❑ No
Do you frequently ask people to repeat themselves ❑ Yes ❑ No
Do you have trouble hearing in noisy situations? ❑ Yes ❑ No
Have others told you that you speak too loudly? ❑ Yes ❑ No
Do others complain your TV is too loud? ❑ Yes ❑ No
Do you have difficulty talking on the phone? ❑ Yes ❑ No
Do you avoid social events because of hearing difficulty? ❑ Yes ❑ No
How many years have you experienced hearing difficulty? _____
Do you currently wear hearing aids? ❑ Yes ❑ No ❑
If so, what brand name and type? _____
If not, will you wear a hearing aid if it can help you hear better and increase the quality of your life? ❑ Yes ❑ No

I hereby consent to the recording (both audio and video) for customer service and quality purposes. I understand that the hearing screening is complimentary but should I request a copy of the results, I will be charged at the discretion of the provider.

Patient Signature _____ Date _____